February 13, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Administrator Brooks-LaSure,

On behalf of the American Association of Psychiatric Pharmacists (AAPP), we appreciate the opportunity to provide feedback on the Centers for Medicare and Medicaid proposed rule on Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (proposed rule). Our comments are below.

About AAPP

AAPP is a professional association of nearly 3,000 members who envision a world where all individuals living with mental illness, including those with substance use and neurologic disorders, receive safe, appropriate, and effective treatment. Members are specialty pharmacists, and most are Board Certified Psychiatric Pharmacists (BCPPs) who specialize in psychiatry, substance use disorders (SUDs), psychopharmacology, and neurology. With a significant shortage of mental health care professionals, psychiatric pharmacists offer another resource to improve outcomes for patients with psychiatric and SUDs.

Role of Psychiatric Pharmacists

Pharmacists today graduate with a Doctor of Pharmacy degree, requiring six to eight years of higher education to complete, and have more training specific to medication use than any other health care professional. Psychiatric pharmacists, a specialty within clinical pharmacy, are primarily board certified and residency-trained mental health care practitioners who have specialized training in providing direct patient care and medication management for the complete range of psychiatric and SUDs. Psychiatric pharmacists work as treatment team members but also in decision-making and leadership roles in state and federal organizations, academia, and industry.

Psychiatric pharmacists are an important member of the health care team working in collaboration with the patient and other health care providers including psychiatrists, other physicians, therapists, social workers, and nurses. Psychiatric pharmacists provide expert, evidence-based Comprehensive Medication Management (CMM) services for the most complex patients with mental health and SUDs. Psychiatric pharmacists increase capacity of the health care team to care, provide psychopharmacology expertise, as well as improve patient outcomes and reduce overall health care costs.

AAPP Comments on Proposed Rule

1. ***CMS should consider replacing Medication Management Therapy (MTM) with Comprehensive Medication Management (CMM).***

AAPP appreciates CMS's audit of the MTM program in Medicare Part D to identify potential disparities and proposed changes that promote consistent, equitable, and expanded access to MTM services. While the changes in the proposed rule may enhance MTM, there remains a critical issue with the program: the pharmacist is not integrated into the health team for a beneficiary. As such, the MA/Part D plan pharmacist can work in a silo and potentially may not have access to important information about the patient and their conditions. CMM, on the other hand, incorporates the clinical pharmacist into the health team. It is a patient-centered approach delivered by the clinical pharmacist working in collaboration with the patient and other health care providers to optimize medication use and improve health outcomes.[1]

CMM is a comprehensive, defined process that ensures patients' medications are individually assessed to determine if the indication of that medication is appropriate and effective for a given medical condition.[2] Additionally, and most importantly, CMM factors into its assessment whether the medications are individually assessed to ensure that each medication is safe, effective, and prescribed for an appropriate indication.[3] Overall, under CMM protocols, a clinical pharmacist's assessment focuses on the goals of the provider, caregiver, and clinicians to determine the best course of action with each medication. This results in reduces costs, and leads to improved outcomes, access to care, patient satisfaction, and provider work-life.[4]

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[1] Patient-Centered Primary Care Collaborative (PCPCC). The patient-centered medical home: integrating comprehensive medication management to optimize patient outcomes resource guide, 2nd ed. Washington, DC: PCPCC, 2012, *available at* https://www.pcpcc.org/sites/default/files/media/medmanagement.pdf. Last visited February 2, 2023.

[2] The Patient Care Process for Delivering Comprehensive Medication Management (CMM): Optimizing Medication Use in Patient-Centered, Team-Based Care Settings. CMM in Primary Care Research Team. July 2018, *available at* https://www.accp.com/docs/positions/misc/CMM_Care_Process.pdf. Last visited February 2, 2023.

[3] Livet M, Blanchard C, Frail C, Sorensen T and McClurg M. Ensuring effective implementation: a fidelity assessment system for comprehensive medication management. J Am Coll Clin Pharm 2020;3:57-67. https://doi.org/10.1002/jac5.1155.

[4] Optimizing Medication Use Through Comprehensive Medication Management (CMM) in Practice, GTMRx Payment Policy Recommendations, May 2022, *available at* https://gtmr.wpenginepowered.com/wp-content/uploads/2022/05/GTMRx-Payment-Policy-Recommendations-Discussion-Document_5.11.22.pdf. Last visited February 6, 2023.

We encourage CMS to consider using CMM in the Part D, as well as Part B, program. This will allow Parts B and D to use the same process, thus streamlining and improving care. Furthermore, CMM is not reimbursed in Part B. We request that CMS revisit reimbursement policies to ensure that these vital services are properly paid for given their proven benefit to patients and the Medicare program at large.

2. ***AAPP supports prior authorization provisions and urges further reforms in future rulemaking***.

While prior authorization is intended to contain health care costs by ensuring that services are medically necessary prior to approval for payment, current prior authorization requirements may create barriers to care which can create confusion, delays, and ultimately may cause harm to patients. [5] A recent survey of over 1,000 physicians conducted by the American Medical Association revealed that prior authorization can lead to absenteeism and a less productive health care workforce.[6] AAPP shares in CMS's goal of patient-centered care and applauds the proposed changes made to prior authorization requirements. Specifically, we agree that:

- Prior authorization policies for coordinated care plans may only be used to confirm the presence of a diagnosis, which will reduce the number of denials.
- An approval granted through prior authorization must be valid for the duration of the approved course of treatment and that plans must provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new plan, which will ensure patients do not have interruptions in coverage when they need it the most.
- MA plans must comply with national coverage determinations (NCD), local coverage determination (LCD), and general coverage and benefit conditions included in statute and regulation, which will help standardize processes.
- MA plans cannot deny coverage of a Medicare covered item or services based on internal, proprietary, or external clinical criteria not found in traditional Medicare policies, which will also standardize processes.
- If there is no coverage criteria in the previously mentioned sources, the MA organizations may create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, which minimize plans claiming that their decision making is proprietary.
- MA plans must establish a Utilization Management Committee to review all utilization management, including prior authorization policies annually, which help ensure compliance.

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[5]Jeannie Fuglesten Biniek and Nolan Sroczynski, Over 35 Million Prior Authorization Requests Were submitted to Medicare Advantage Plans in 2021, Kaiser Family Foundation, February 2, 2023, *available at* https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/#:~:text=Prior%20authorization%20is%20intended%20to,covered%20by%20a%20patient's%20insurance. Last visited February 3, 2023.

[6] Andis Robeznieks, Why prior authorization is bad for patients and bad for business, AMA, February 18, 2022, available at https://www.ama-assn.org/practice-management/prior-authorization/why-prior-authorization-bad-patients-and-bad-business. Last visited February 3, 2023.

In future rulemaking, we request CMS consider policy changes to reflect clinical validity and transparency and fairness related to prior authorization.

3. ***AAPP supports proposed behavioral health provisions and encourages CMS to utilize psychiatric pharmacists to advance goals to improve health care.***

As behavioral health issues become more prominent and it becomes clear that their integration into primary care is necessary, policy changes are needed to ensure greater access to behavioral health. To that end, AAPP appreciates the proposed changes in this rule related to improving access for such services.

We support amending the general access to services standards to include behavioral health services and clarifying that emergency medical services that must not be subject to prior authorization include behavioral health services to evaluate and stabilize an emergency medical condition.

Additionally, we support requiring MA organizations to establish care coordination programs including coordination of community, social and behavioral health services. This will help improve parity between behavioral and physical health services and advance whole-person care, goals psychiatric pharmacists are uniquely situated to advance. Through their experience collaborating with health care teams and comprehensive understanding of patients' health care needs, psychiatric pharmacists can serve as a bridge to community and social services. For example, psychiatric pharmacists can screen and refer patients with food insecurity to community resources (e.g., supplemental nutrition assistance programs), screen and refer patients with serious health conditions such as schizophrenia for intensive case management services. In addition, psychiatric pharmacists counsel patients on the minimum amount of food required for medication to work and may recommend alternative medications for patients with food insecurity. They also screen for safety in patient homes and refer them to community domestic violence support or youth services, and screen and connect patients with local Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) resources available in their communities.

Thank you again for the opportunity to comment. If you have any questions, please do not hesitate to contact me or our Health Policy Consultant, Laura Hanen at lahanen@venable.com.

Sincerely,

Brenda Schimenti

Brenda K. Schimenti
Executive Director